Date:________________

Child Welcome Information

Patient's Name____Nickname ____________________
Last First Middle

Address____
Street City State Zip

Home Phone___________________ Date of Birth ___________________ SSN _____________________________

School_________________Grade_____Hobbies or special interests?____

Are there siblings? (names/ages)____Dentist______________________

Whom may we thank for referring you to our office? (Check all that apply):

- ☐ Dentist________________________________
- ☐ Friend/Family/Neighbor___________________
- ☐ Internet (Where specifically?)______________
- ☐ Other_________________________________
- ☐ Mansfield Cares
- ☐ Miles for Meredith
- ☐ School Field Trip
- ☐ Mansfield ISD Education Foundation
- ☐ Feed the Kids
- ☐ Location

What are the main concerns that you would like orthodontics to accomplish?____________________________________

Dental Status

When was the patient last seen by the dentist? ____

- ☐Yes ☐No Has the patient had previous orthodontic treatment or consultation? When? Why? ______________
- ☐Yes ☐No Has any member of the family had orthodontic treatment?__________________________________
- ☐Yes ☐No Has the patient had any trouble associated with dental treatment? ___________________________
- ☐Yes ☐No Has the patient had any teeth extracted? Why? ____
- ☐Yes ☐No Has the patient ever injured or broken any teeth? When and what happened? __________________
- ☐Yes ☐No Has the patient ever injured the head or face? When and what happened? ____________________
- ☐Yes ☐No Does the patient have any missing or extra teeth? _______________________________________
- ☐Yes ☐No Does the patient have any problem with eating, chewing, or swallowing? _____________________
- ☐Yes ☐No Does the patient suck thumb, fingers, tongue, blanket, or pacifier? (circle which) ________________
- ☐Yes ☐No Does the patient have any dental or facial pain?____
- ☐Yes ☐No Does the patient's jaw joint make noises or hurt when opening, closing, or chewing?______________
- ☐Yes ☐No Does the patient habitually grind or clench the teeth together? ______________________________
- ☐Yes ☐No Does the patient normally breathe with the lips parted? ___________________________________
- ☐Yes ☐No Is the patient aware of any swellings or growths in the mouth or face? _________________________
- ☐Yes ☐No Does the patient have negative or resistant feelings about orthodontic treatment? _______________
- ☐Yes ☐No Is the patient especially concerned about orthodontic treatment?_______________________________
- ☐Yes ☐No Is the patient dissatisfied with the appearance of the teeth?__________________________________
- ☐Yes ☐No Is the patient especially resistant to: ☐ Braces ☐ Headgear ☐ Retainers
- ☐Yes ☐No Is there any other information we should know?____

Medical History

Please list any:

Serious illness or condition ____

Allergies or known drug sensitivity ____

Current medical care ____

Current medications ____

Tonsils and Adenoids: ☐ Present ☐ Removed at age ________

☐Yes ☐No Does the patient have frequent colds or ear infections?

Has the patient ever been diagnosed or treated for the following (Check all that apply.):

- ☐ Rheumatic Fever
- ☐ Heart Murmur
- ☐ Heart Condition
- ☐ High Blood Pressure
- ☐ Endocrine Disorders
- ☐ Bone Disorder
- ☐ Emotional Problems
- ☐ Multiple Sclerosis
- ☐ Asthma
- ☐ Epilepsy
- ☐ Herpes
- ☐ Hepatitis
- ☐ Low Blood Pressure
- ☐ Tuberculosis
- ☐ Bleeding Disorder
- ☐ Cerebral Palsy
- ☐ Cancer
- ☐ AIDS or HIV+
- ☐ Arthritis
- ☐ Diabetes

Responsible Party Information

Name____ Relationship to Patient ______________
Last First Middle

Residence ____
Street City State Zip

Mailing Address ____
Street City State Zip

How long at this address_________ Rent or Own?______________

Previous Address (if less than 3 yrs.) ____
Street City State Zip

SSN ______________________________ Date of Birth ______________________________ Marital Status ____________________________

Home Phone________________ Work Phone________________ Cell Phone ________________ E-mail ________________________

Employer __________________________ Occupation ___________________ No. Years Employed __________________

Employer's Address ____
Street City State Zip

Spouse's Name____ Relationship to Patient ____________________
Last First Middle

SSN ______________________________ Date of Birth ______________________________

Work Phone________________ Cell Phone ________________ E-mail ________________________

Employer __________________________ Occupation ___________________ No. Years Employed __________________

Employer's Address ____
Street City State Zip

A B C

Insurance Information

Insured's Name____ Relationship to Patient _______________________
Last First Middle

Insured's Mailing Address ____
Street City State Zip

Insured's SSN ___________________ Insured's Date of Birth _________________ Home Phone ________________ Work Phone _______________

Insurance Company ______________________________Group No. _______________ Local No. _______________ Employer __________________

Insurance Co. Address____
Street City State Zip

Insurance Co. Phone____________________________

Do you have dual coverage? ☐Yes ☐No If yes:

Insured's Name____ Relationship to Patient _______________________
Last First Middle

Insured's Mailing Address ____
Street City State Zip

Insured's SSN ___________________ Insured's Date of Birth _________________ Home Phone ________________ Work Phone _______________

Insurance Company ______________________________Group No. _______________ Local No. _______________ Employer _________________

Insurance Co. Address ____
Street City State Zip

Insurance Co. Phone____________________________

Signature of Responsible Party

To the best of my knowledge, the information given is correct. Furthermore, I understand that it is my responsibility to inform this office of any changes in this patient's medical status or insurance information. I authorize Dr. Herrmann to perform a complete orthodontic evaluation including digital photos and 3D digital x-rays. I also understand that diagnostic records and name may be used in educational and promotional purposes. I also understand that in order to receive complete information on financial options, credit bureau reports may be obtained.

Signature: _____________________________________ Relationship to Patient: ______________________________ Date: _____________________